Federal classification and patient assessment forms and surveys

The MDS

In 1986 the Institute of Medicine (IOM) issued a study entitled, "Improving the Quality of Care in Nursing Homes" (16). The focus of the study was to examine ways to improve the regulation of nursing homes to improve quality of care. A core theme that emerged from that study was the need to standardize assessment and care planning for nursing home residents. Congress subsequently passed a law in 1987 that required the development of the MDS to ensure that each nursing home resident receives, at regular specified intervals, a comprehensive assessment and care plan designed to meet his/her needs. CMS (formerly known as the Health Care Financing Administration (HCFA)) developed the MDS based on input from various disciplines. The MDS assessment includes more than 583 items that are used by facilities in performing comprehensive assessments of their residents. Thirteen domain areas are included in the MDS assessment: past medical history and medically defined conditions, medical status, functional status, physical and sensory impairments, nutritional status, special treatments or procedures, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognition, and drug therapy.

Nationwide electronic collection of the MDS began in the 1990s. As required by statute for assessment and care planning, the MDS is required to be completed shortly after admission**,** annually, and quarterly thereafter. It is also required upon a significant change in the resident's condition. In most states, a shorter form is used for quarterly assessments than for the more comprehensive admission and annual assessments.

The MDS is a paper and pencil assessment form that summarizes data from a variety of sources, may be completed by person who are not knowledgeable about the resident, and is eventually encoded and transmitted electronically to State and Federal governments.

MDS forms are used for a variety of purposes:

- Comprehensive assessment and care planning;

- Medicare, and, in some States, Medicaid payments;
- Construction of quality indicators used in the survey process and as a source of public information; and
- Construction of quality measures used as a source of public information.

The FIM

The Functional Independence Measure (FIM) was developed in the early 1980's by the State University of New York at Buffalo with the cooperation of many provider and advocate groups through a grant from the Department of Education. The FIM consists of 18 items. The 18 items are broken into 13 motor items and 5 cognitive items. The motor items are broken into 4 sub groups consisting of Self Care, Sphincter Control, Mobility, and Locomotion. There are 2 sub groups of cognitive items which are Communication and Social Cognition. The individual FIM items include: Eating, Grooming, Bathing, Dressing Upper Extremities, Dressing Lower Extremities, Toileting (Self Care), Bowel Management, Bladder Management (Sphincter Control), Bed Transfers, Toilet, Transfers, Tub Transfers (Mobility), Walking or Wheelchair Locomotion, Stairs (Locomotion), Comprehension, Expression (Communication), Social Interaction, Problem Solving, and Memory (Social Cognition). The 18 items are scored on a 1 to 7 scale with 1 being the most dependent and 7 being independent. The lowest possible score is 18 with the highest being 126.

The overall purpose of the FIM is to measure outcomes of patients with various disabilities. FIM has been and continues to be used internationally in hundreds of hospitals. The instrument is used in various ways in the Department of Veterans Affairs (VA) Hospitals. The tool has been used to track outcomes of patients undergoing inpatient rehabilitation for over 15 years. More recently certain patient populations, (strokes, amputations, and brain injuries) have been tracked across the continuum of care as a mechanism of quality control across the VA system. Scores are completed initially when a patient is medically stable and then again when a patient has completed a course of treatment. In addition to Initial and Discharge Scores, the data can be captured at various times during the course of treatment (Interim FIMs) and at points after treatment

(Follow up FIMs). So depending on the length of treatment there can be dozens of assessments on any given patient. There are various calculations that can be generated with the data and various comparisons can be made both within the VA system and with private sector hospitals.

The data can be entered directly in the patient's electronic medical record and then can be electronically sent to the VA Austin Automation Center (AAC) which houses the national data. The data can also be collected manually and then entered in the VA AAC data base. Quarterly, the AAC sends data to the Uniform Data System for Medical Rehabilitation (UDSmr) which aggregates the data for individual VA's and for the whole VA system and generates reports which are sent back to medical centers and to VA Headquarters.

The individual medical centers use the data for quality assurance activities, performance measurement, educational endeavors and, to a limited degree, for marketing. The data is also used to demonstrate the above activities to accreditation agencies such as the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) and the Commission on the Accreditation of Rehabilitation Facilities (CARF).

The OASIS

The **O**utcome and **AS**sessment **I**nformation **S**et (OASIS) is a group of data elements that: 1) represent core items of a comprehensive assessment for an adult home care patient; and 2) form the basis for measuring patient outcomes for purposes of outcome-based quality improvement (OBQI).

Most data items in the OASIS were derived in the context of a CMS-funded national research program (co-funded by the Robert Wood Johnson Foundation) to develop a system of outcome measures for home health care. This program, and the OASIS, have evolved over a ten-year developmental period. The core data items were refined through several iterations of clinical and empirical research. Other items were added later by a work group of home care experts to augment the outcome data set with selected items

deemed essential for patient assessment. The goal was not to produce a comprehensive assessment instrument, but to provide a set of data items necessary for measuring patient outcomes and essential for assessment - which HHAs in turn could augment as they judge necessary. Overall, the OASIS items have utility for outcome monitoring, clinical assessment, care planning, and other internal agency-level applications.

Main Components and General Application --

OASIS data items encompass sociodemographic, environmental, support system, health status, and functional status attributes of adult (nonmaternity) patients. In addition, selected attributes of health service utilization are included.

In addition to measuring patient outcomes, OASIS data have three important uses in the areas of: 1) patient assessment and care planning for individual adult patients; 2) agency-level case mix reports that contain aggregate statistics on various patient characteristics such as demographic, health, or functional status at start of care; and 3) internal HHA performance improvement.

CMS requires that HHAs collect OASIS data and requires that they report OASIS to their State survey agency. HHAs are required to electronically transmit OASIS data to the standard State system, which has been installed by CMS. CMS has installed the additional software to accommodate this data transmission in each State. The State agencies have the overall responsibility for collecting OASIS data in accordance with CMS specifications. The State is also responsible for preparing OASIS data for retrieval into the CMS central data repository. One of the purposes of OASIS automation is to fulfill the HHA provisions of the Balanced Budget Act (BBA) of 1997. The BBA includes a Medicare requirement for HHA prospective payment that depends on the data acquired by the OASIS system. That provision of the BBA became effective for HHAs' cost reporting periods beginning in FY 2000. Another CMS purpose was to provide States with enhanced ability to direct on-site HHA inspection resources through the use of OASIS data.

The IRF-PAI

OVERVIEW OF INPATIENT REHABILITATION FACILITY PATIENT ASSESSMENT INSTRUMENT (IRF-PAI)

The IRF-PAI is a patient assessment instrument used in inpatient rehabilitation facilities. It was designed to support the development and implementation of the IRF prospective payment system (IRF PPS). Specifically, the patient assessment data is used for: (a) objective assignment of Medicare beneficiaries to appropriate IRF payment groups; (b) development of a system to monitor the effects of IRF PPS on patient care and outcomes; (c) determination of whether future adjustments to the IRF payment groups are warranted; and (d) development of an integrated system for post-acute care in the future. Assessments are completed at admission and discharge for Medicare fee-for-service IRF patients.

The IRF-PAI consists of nine sections, each to collect different categories of patient information. These categories include identification and demographic information about the patient, medical information, and information related to quality of care and basic patient safety.

The functional status section of IRF-PAI utilizes the Functional Independence Measure (FIM) instrument. The FIM measures functional status using 18 items covering 6 domains: self-care or ADLs (6 items), sphincter control (2 items), mobility (3 transfer items), locomotion (2 items), communication (2 items), and social cognition (3 items). All 18 items are scored into one of 7 levels of function ranging from complete dependence to complete independence. The FIM was developed by researchers who were funded by a consortium of rehabilitation professional associations and the Department of Education at the State University of New York (SUNY) at Buffalo in the 1980s. The FIM is marketed by the UDSmr, maintained by SUNY/Buffalo, and is proprietary.

Beginning on January 1, 2002, IRFs were required to collect, computerize and electronically report IRF-PAI data for Medicare fee-for-service patients to CMS.

While the IRF-PAI data are used principally for payment purposes at the present time, CMS has a current ongoing project to develop quality measures based on items contained in the IRF-PAI (including the FIM).

The RFC

The Social Security Administration uses separate RFC forms to assess *Physical Residual Functional Capacity Assessment* and *Mental Residual Functional Capacity Assessment* and a separate form to assess childhood function.

For more information on the forms, I refer you to http://policy.ssa.gov/poms.nsf/36f3b2ee954f0075852568c100630558/a116a4e73142c33985256db500766c31?OpenDocument

A residual functional capacity form is to be completed on any adult who applies for disability benefits (Title II or Title XVI) and for whom the medical evidence of record (MER) does not meet or equal one of the Listings in the Listing of Impairments.

Childhood function is assessed as part of the Listing of Impairments for children; therefore, these are completed on every child applicant.

While the paper forms are currently the norm, electronic versions of the forms are being rolled out on a progressive basis as part of SSA's efforts to have a totally electronic record. As a point of clarification, forms are either recorded on paper or electronically; there is no conversion of one format to the other. Generally, only one form is completed for each applicant; however, more than one form for each applicant may be completed when the MER is reviewed by more than one physician.

There are 11 functional items on the Physical RFC form, 20 functional items on the Mental RFC form, and about 10 functional items on the childhood forms (there are several forms as the forms are age-related).

NCHS Surveys

In August 2003, staff of the National Center for Health Statistics/Centers for Disease Control and Prevention (NCHS/CDC) developed a list of over 300 terms used in these major NCHS surveys: the National Health Interview Survey (NHIS); the 1994-95 National Health Interview Survey- Disability Supplement (NHIS-D); the 2002 National Health Interview Survey - Disability and Secondary Conditions Supplement (NHIS-DS); and the third National Health and Nutrition Examination Survey (NHANES-III). This list of terms proved to be too large for analysis given the limited time frame, and in November, was pared down to about 50 items. Therefore, the subsample of sampled questions suggests that conclusions based on any analysis must be tentative.

The NHIS is a continuous, nationwide, household interview survey of the U.S. civilian non-institutionalized population conducted by NCHS/CDC. A national probability sample of households is interviewed each week throughout the year. The NHIS consists of a core, plus one or more special health questionnaires that vary from year to year. About 40,000 households are sampled, and a sample adult is interviewed in home if possible. Proxy responses are allowed for sample persons who cannot answer the questions for themselves because of a heath limitation or condition. Information is collected on over 100,000 persons in those households. Sample data are weighted up to national estimates. The main objective is to estimate the national prevalence of selected health, disease, and risk factors. Progress towards Healthy People 2000 and 2010 objectives is also assessed.

The 1994-95 NHIS-D was a supplement to the 1994 NHIS. In the NHIS-D, Phase I requested additional information on assistive devices as well as health conditions, activities of daily living (ADL), instrumental activities of daily living (IADL), special health needs of children, perceived disability, and disability conditions. Based on

responses to Phase I questions, respondents were contacted again for more detailed disability information. Sample data are weighted up to national estimates.

In the 2002 NHIS-DS, a special health questionnaire on disability and secondary conditions was included. The focus was on special equipment, assistive devices, and social and physical barriers which limit people with disabilities in home situations, school situations, work situations, and community activities.

NHANES-III was the third National Health and Nutrition Examination survey and it is a 6-year survey covering the years 1988-94. Over the 6-year period, 39,695 persons were selected for the survey, of which 30,818 (77.6%) were examined in the mobile examination center. The target population is the civilian non-institutionalized population 2 months of age and over. The objectives are to contribute to an understanding of disease etiology, investigate the natural history of selected diseases, and estimate national population reference distributions of selected health parameters.